Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

MARTIN B JONES MD
PO BOX 741865
DALLAS TX 75374

Respondent Name

OLD REPUBLIC INSURANCE CO

Carrier's Austin Representative Box

Box Number 42

MFDR Tracking Number

M4-11-0735-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "REQUIRED TESTING REQUESTED BY THE DD"

Amount in Dispute: $49.28

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Dispute notice was sent on November 17, 2010. No response to MFDR.

Response Submitted by: NA

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 16, 2010	95851	$49.28	$49.28

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out Medical Fee Guidelines for workers' compensation specific services.
3. 28 Texas Administrative Code §134.203 sets out Medical Fee Guidelines for Professional Services.

4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated April 27, 2010
   - W1 – WORKERS COMP STATE FEE SCHED ADJUST. THE REIMB FOR DETERMINATION OF MMI AND/OR IMPAIRMENT RATING (99456) SHALL INCLUDE THE EXAM, REVIEW OF RECORDS/FILM, RANGE OF MOTION, STRENGTH AND SENSORY TESTING & MEASUREMENT.

Issues

1. Was the Range of Motion performed in conjunction with an extent of injury determination included in that evaluation?
2. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.204(k), testing shall be billed using the appropriate CPT codes & reimbursed in addition to the examination. The complete billing is for CPT code 99456-RE-W6 which was paid and not in dispute. However, the complete billing including the Range of Motion (ROM) CPT code 95851 has to be taken into account to determine if the disputed CPT code 95851 is payable. Review of the documentation and billing of 2 units shows that (ROM) measurements were performed to the cervical spine as well as to the lumbar. These were done in support of a Designated Doctor exam for determination of extent of injury (99456-W6-RE), not for determining MMI/IR and therefore are not global.
2. Per 28 Texas Administrative Code §134.203(c), the MAR is calculated for the zip code 76104 for Fort Worth, (Tarrant County). The MAR for 2 units of CPT code 95851 is $49.38. As the Requestor has disputed a lesser amount, $49.28, the requested amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $49.28.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $49.28 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	September 28, 2011 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.